Commonwealth of Massachusetts
Group Insurance Commission
P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

INSURANCE DATA FORM (IDF)

PLEASE TYPE OR PRINT CLEARLY

This form is required for new enrollments in any Group Insurance Commission family health plan and for any changes in spouse or dependents. Complete it and any other health plan forms provided by your Group Insurance Coordinator and return them to the Coordinator. If you are a retiree, please return the form to the GIC. Please PRINT clearly. Incomplete forms will be returned.

CHECK ONE: ☐ **NEW MEMBER** ☐ **ADDITION** ☐ **DELETION** ☐ **CORRECTION**

INSURED INFORMATION:

1. Name: _____
Last First Middle

2. Address: _____
Street

_____
City State Zip Code

3. Social Security Number: _____ 4. Date of Birth _____ 5. Sex ☐ M ☐ F
Month Day Year

6. Health Plan (Check one): ☐ Commonwealth Indemnity ☐ Commonwealth Indemnity PLUS ☐ Commonwealth Indemnity Community Choice
☐ Navigator By Tufts Health Plan ☐ Harvard Pilgrim POS
☐ HMO Name: _____

7. Are you enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim # _____

SPOUSE/DEPENDENT INFORMATION:

List below all family members, including your spouse, who will be covered under your family plan. Please provide all Social Security Numbers and **exact** dates of birth for each dependent. Coverage for all children ends at age 19 , except for full-time students and handicapped dependents whose applications have been approved by the Group Insurance Commission. Married children are not eligible. Attach separate sheet if additional space is required.
Important: You are required to provide a copy of a marriage certificate, birth certificate, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. Failure to provide this documentation will result in your spouse/dependent not being covered.

Last Name	First	Middle	Relationship	Date of Birth	Sex	Social Security Number

Reason for addition or deletion: _____ Effective date: _____

SPOUSE INFORMATION:

Is your spouse employed? ☐ Yes ☐ No Name of employer _____

Address of employer : _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

Name of insurance company _____ Policy/Certificate Number _____

Address of insurance company _____

Are you and/or your children covered under your spouse's group health insurance plan?

You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No

If yes, Medicare claim number _____

FORMER SPOUSE:

Name: _____
Last First Middle

Address: _____
Street

_____
City State Zip Code

Social Security Number _____ Date of Birth _____ Date of Divorce _____

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

IMPORTANT: YOU MUST SIGN BELOW

Signed under the pains and penalties of perjury, I certify that the information I have provided is, to the best of my knowledge, complete and accurate.

Signature _____ Date _____

TO BE COMPLETED BY GIC COORDINATOR: **Dept. ID # or Agency/Division #** _____

Name of GIC Coordinator _____

Agency Name _____

Agency Address _____ Agency Telephone Number _____

ACTIVE EMPLOYEES: RETURN COMPLETED FORM TO YOUR GIC COORDINATOR
RETIREES: RETURN COMPLETED FORM TO THE GIC

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